This form may be completed online, printed and mailed to the address listed below.

STATE OF NEBRASKA
Department of Health and Human Services
REGULATION AND LICENSURE - Credentialing Division
P.O. Box 94986 - Lincoln, Nebraska 68509-4986
Telephone #: 402-471-2117

ATTACHMENT B

APPLICATION TO BEGIN A TRAINING PROGRAM NURSING HOME ADMINISTRATION

Please check type of application below:

❒ Administrator-in-training
❒ Mentoring Program

FEE: $15.00

SECTION A – PERSONAL INFORMATION				
1.	Name:	First:	Middle/Initial:	Last:
2.	Address:	Street/PO/Apt/Route:		
		City	State	Zip Code
3.	Telephone # (Optional):			

SECTION B – PRECEPTOR/FACILITY INFORMATION				
1.	Name of Preceptor:	First:	Middle/Initial:	Last:
2.	Preceptor #:			
3.	Name of Facility where Training will Occur:			
4.	Address of Nursing Home:	Street/PO/Apt/Route:		
		City:	State:	Zip Code:
5.	Telephone # (Optional):			

SECTION C – DATES OF TRAINING			
1.	Proposed Starting and Ending Date of Training	Start:	End:
2.	Number of Hours of Training per Day		
3.	Number of Hours Trained per Week		

SECTION D – ATTESTATION (This section must be completed by all applicants)

I hereby state that I am the person making application, I am of good moral character, and the statements on this application are true and complete.

I further state that:

❒ I have not practiced in Nebraska prior to this application for licensure; **or**
❒ I have practiced for ____ number of days in Nebraska prior to this application for licensure.

_____
(Signature of Applicant)

_____ date

ATTACHMENT B1

AGREEMENT BETWEEN A PRECEPTOR
AND ADMINISTRATOR-IN-TRAINING OR MENTORING TRAINEE

(Print or Type)

(This Form must be completed by the certified NHA Preceptor and
signed by the Preceptor and Trainee before a Notary Public)

Please check type of application below:

❒ Administrator-in-training
❒ Mentoring Program

To the Board of Examiners in Nursing Home Administration, State of Nebraska:

I hereby state that I have entered into an agreement to provide an adequate Administrator-in-Training Program or Mentoring Program as indicated above, to _____ (trainee name), which will consist of at least **640** hours of training and experience, and will be gained in not less than **4** months (gained in not less than **20** hours per week), and will follow the guidelines established in the monthly report forms.

PRECEPTOR MUST COMPLETE THIS SECTION:	**TRAINEE MUST COMPLETE THIS SECTION:**
_____	_____
Legal Signature of Preceptor	Legal Signature of Trainee
Date: _____	Date: _____
Name: _____	Name: _____
Address: _____	Address: _____
_____	_____

FORWARD THIS COMPLETED FORM TO:
Department of Health and Human Services Regulation and Licensure
Credentialing Division
P.O. Box 94986
Lincoln, Nebraska 68509-4986